

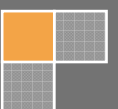
2008

National Accreditation of Community Service Providers to Individuals with Intellectual and Developmental Disabilities

A Survey of 50 States

The Missouri Department of Mental Health, Division of Mental Retardation and Developmental Disabilities engaged HSRI to conduct a survey of the 50 states to determine current state quality management practices pertaining to provider national accreditation.

Human Services Research Institute
www.hsri.org



CONTENTS

EXECUTIVE SUMMARY	3
PURPOSE AND BACKGROUND	4
METHODOLOGY	6
FINDINGS	7
State Position on National Accreditation	7
Accredited Services	8
Tracking Provider Accreditation Status	11
Funding Accreditation	13
Public Reporting	13
States' Recommendations to Other States	14
IMPLICATIONS FOR MISSOURI DMH QUALITY MANAGEMENT	17
ENDNOTES	19
ATTACHMENT A: SURVEY QUESTIONS	20

EXECUTIVE SUMMARY

The State of Missouri is considering changes to its quality management practices that would require national accreditation for providers of community based services to individuals with intellectual and/or developmental disabilities (I/DD). Because this represents a significant change in policy and practice, the Division of Mental Retardation and Developmental Disabilities (DMRDD) sought information on the extent to which states have integrated national accreditation into state level quality monitoring activities. DMRDD contracted with the Human Services Research Institute (HSRI) to survey state officials regarding their quality management practices pertaining to community provider accreditation.

National accreditation is a phenomenon operating in many fields (hospital quality, educational quality, insurance agencies, child care centers, law enforcement and public safety agencies)ⁱ and is largely accepted as a means to ensure that a provider has met a standard of practice. The goals of national accreditation are similar to those of state quality management systems -- service and organizational improvement, the well-being of individuals served, and the encouragement of best practice.

The place of accreditation within public I/DD systems is part of a larger conversation about the balance between public quality management and the outsourcing of some quality assurance functions to private entities. At least three states, South Carolina, Florida and Indiana, have contracted out significant pieces of their quality assurance systems to private for profit and not for profit companies. Therefore the question posed by Missouri to other states regarding the status of accreditation within the formal quality assurance system should be of interest to public managers around the country.

Synopsis of Methodology

This survey was conducted online by respondents in state quality improvement departments. Forty six of the fifty states provided information on their states' practices regarding national accreditation for providers of community based services.

Synopsis of Key Findings

The majority of states (70%) neither require nor formally encourage national accreditation for community based providers. Furthermore, a change in policy along these lines is not anticipated in the near future. In states where accreditation is required or formally encouraged (30%), this expectation is laid out most frequently in administrative rule, followed by statute and least often resulting from a court mandate. States are more likely to encourage/require accreditation of day services (e.g., sheltered workshops, rehabilitation services, supported employment) than residential services.

This practice appears to be long standing as policies regarding accreditation of day services in 10 states are noted to have in place for more than 10 years.

Of interest is the extent to which state oversight requirements are waived when a provider has a current certificate of national accreditation. States that require or encourage provider accreditation are equally split between those that waive requirements and those that do not. Most frequently waived is provider certification. When we examine states that require provider accreditation for certain services (seven states), just one state waives an element of its provider oversight and monitoring (provider certification).

The majority of states that require or encourage accreditation track the accreditation status of community providers. Beyond accreditation review results however, communication between state agencies and accreditation organizations regarding issues of concern with a provider's performance are almost equally likely to occur as not. No state currently evaluates the performance of accredited providers with non-accredited providers serving individuals with similar needs.

Few states at this time readily share provider specific accreditation information with the public. But states are interested in posting provider performance information. States that HSRI has worked with over the past several years are actively contemplating ways to display provider performance data and present more transparent systems to stakeholders. Accreditation results are one source of performance information that stakeholders may find useful.

This survey concluded by querying public I/DD service system managers to share provider accreditation and quality monitoring experiences and suggestions with Missouri DMRDD officials regardless of whether a state has formal rules or policies regarding provider accreditation.

Synopsis of Recommendations

The predominant message from state quality managers that responded to this survey is that accreditation is an adjunct quality assurance process that complements, but does not replace, state quality monitoring. Very few states waive any part of the quality oversight functions for community providers with national accreditation. Accreditation, while recognized as a valuable indicator of a provider's quality of service delivery, is not recommended to stand in lieu of a state's responsibility to assure that individuals receiving services are meeting state standards. States participating in this survey recommend utilizing national accreditation as one source of information to discern community provider performance.

PURPOSE AND BACKGROUND

National accreditation is a phenomenon operating in many fields (hospital quality, educational quality, insurance agencies, child care centers, law enforcement and public safety agencies) and is largely accepted as a means to ensure that a provider has met a standard of practice. In the field of services to those with intellectual and developmental disabilities (I/DD), the primary accreditation organizations are non profit, private entities:

- Commission on Accreditation of Rehabilitation Facilities (CARF)
- The Council on Quality and Leadership (CQL)
- Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
- Council on Accreditation (COA)

The goals of national accreditation are similar to those of state quality management systems -- service and organizational improvement, the well-being of individuals served, and the encouragement of best practice. Further, as public I/DD systems have begun to emphasize the importance of valuing individual outcomes, accreditation organizations likewise have incorporated individual outcomes into performance expectations.

Unlike state quality management systems, however, national accreditation survey tools are typically standardized for use across the nation. Because the standards are national, the rubrics used to make distinctions among agencies regarding performance may differ from the standards and policies of a particular state. Thus state managers may be interested in adapting national accreditation survey tools to reflect cultural, historical and policy constructs important to a particular state. There is also the question of who accredits the accreditation agencies? In the U.S., accreditation entities for accreditation organizations exist (particularly in higher educationⁱⁱ) although not in the field of I/DD accreditation organizations.

The place of accreditation within public I/DD systems is part of a larger conversation about the balance between public quality management and the outsourcing of some quality assurance functions to private entities. At least three states, South Carolina, Florida and Indiana, have contracted out significant pieces of their quality assurance systems to private for profit and not for profit companies. Therefore the question posed by Missouri to other states regarding the status of accreditation with the formal quality assurance system should be of interest to public managers around the country.

METHODOLOGY

Respondents targeted for this survey were quality management staff in state systems serving individuals with intellectual and developmental disabilities. The national accreditation agencies encompass entities that assess the quality of services and supports to people with I/DD. Examples of national accreditation organizations in the field of developmental disabilities include CARF (formerly the Commission on the Accreditation of Rehabilitation Facilities), the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), The Council on Quality and Leadership (CQL), and the Council on Accreditation (COA).

HSRI and Missouri DMRDD quality management staff designed a survey (see Attachment A) that covers five areas of inquiry:

- State position on national accreditation of community providers
- Tracking provider accreditation status
- Funding accreditation
- Public reporting and
- Recommendations to other states.

An invitation to participate was emailed to all 50 states with a description of the purpose and use of the information. States accessed the survey via customized links. An important incentive to participate was the offer to share this report of findings with participating states.

Respondents were advised that survey information would be held confidential and that the written report would not identify states. States had the option to waive confidentiality and volunteer to be identified to DMRDD staff – should DMRDD staff want to follow up with a state responding in a particular way for additional information. Nearly every state provided permission to share their identity with DMRDD staff.

States were advised that they could participate via telephone or hard copy of a survey. Two states participated by phone and one via hard copy. Targeted respondents that had not responded were sent reminder emails after 10 days. A third contact was made by telephone to speak with the few remaining non-respondents. The data collection period was just over four weeks; 46 states participated, yielding a response rate of 92%.

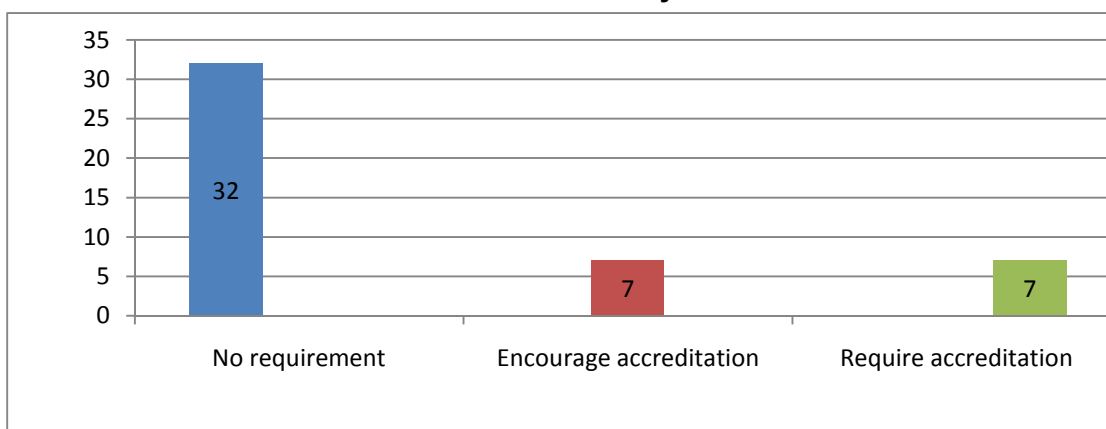
FINDINGS

The results below are based on the responses from 46 state managers within the quality assurance departments of state agencies providing services to individuals with intellectual and developmental disabilities. With this response rate there is a high degree of confidence that results can be generalized to all states.

State Position on National Accreditation

At the time of this survey, the majority of state officials (70%, 32/46 states) report that their quality management practices do not include formal policies that either require or encourage providers of community services be nationally accredited. And further, these states report that they do not anticipate adopting such policies and practices in the near future. However, a substantive number of states (30.4%, 14/46 states) do either require or encourage provider accreditation. In seven states, accreditation is required and in another seven states, accreditation is encouraged. Chart A below displays state positions with respect to community provider national accreditation for the 46 survey respondents.

Chart A. Position of States on Community Provider Accreditation



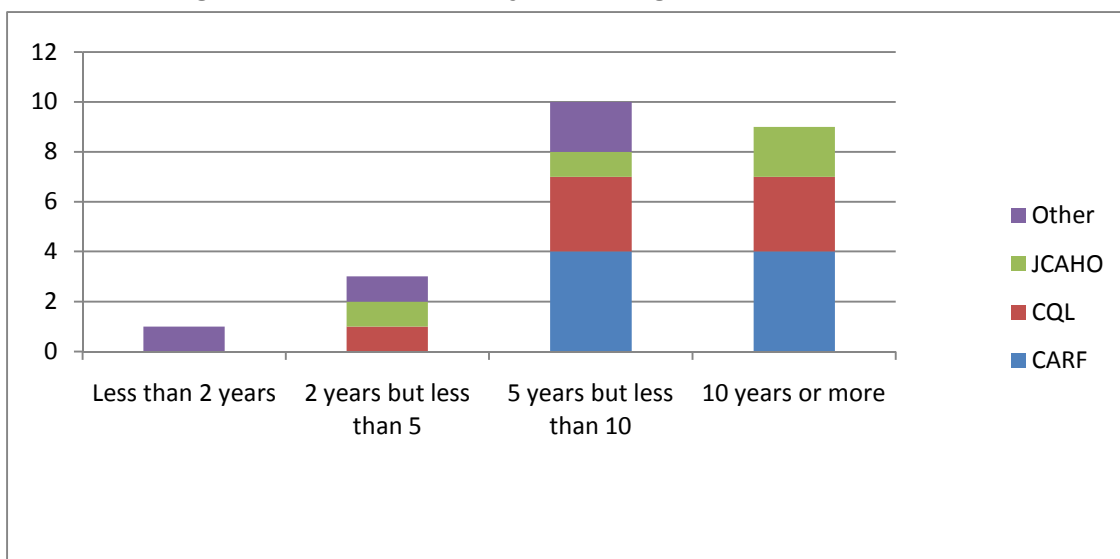
The 14 states with accreditation policies report that accreditation policies are predominately based in administrative rule (64%), followed by statute (29%). Only one state founded its accreditation policy as a result of a court ruling or mandate. Seven of these states offered further explanation of the authority. Below are examples of that variety from different states:

- Accreditation is based in rule for providers earning more than \$250,000/year.
- Licensing and certification regulations deem services other than day habilitation. Accreditation by CARF for Medicaid funded day habilitation services is written into the state's Medicaid regulations.

- Administrative rules encourage a particular quality monitoring review by the DD agency. Providers may choose either the state as reviewers or the accreditation agency CQL. To date, all providers have chosen CQL.
- Administrative rule provides for regional centers to monitor providers of habilitation services for program effectiveness including compliance with applicable CARF standards.

How long have state policies been in place that either encourage or require national accreditation? The range is wide -- from as recently as two years ago to policies implemented 22 years ago. When timeframes are aggregated we found two modes of policy implementation. States implemented accreditation policies most often either between 5 and 10 years ago (10 states) or more than 10 years ago (9 states). Chart B below illustrates the length of time state policies have been in place by specific I/DD service accreditation organization. (Note: In several states policies were established at different points in time depending on the service.)

Chart B. Length of Time State Policy Encouraged/Required Accreditation



Accredited Services

Do the 14 states with accreditation policies stipulate particular accreditation entities by type of service? For ICF/MR, residential (i.e., group home), supported living and services in family or adult homes, the majority of these states do not specify an accreditation entity. However, this changes when day services and work supports are examined. For day/work services, these states are more likely to prescribe the accepted accreditation entity.

Within the sphere of residential supports, when an accreditation entity is specified, the most frequently cited are CQL and CARF. For day and work services, CARF appears more often recommended followed by CQL. Refer to Table 1 below for a distribution of accreditation policy specificity of accreditation organization by service type. For each type of service, states noted all accreditation organizations applicable for that service.

Table 1. Accreditation Entity Stipulated by Service Type

	No policy	CARF	CQL	JCAHO	Other**	Response Count
ICF/MR	60% (6)	10% (1)	10% (1)	20% (2)	20% (2)	10
Residential i.e., group home	57% (8)	29% (4)	36% (5)	7% (1)	7% (1)	14
Supported living	57% (8)	29% (4)	36% (5)	7% (1)	7% (1)	14
Family care/adult homes	65% (9)	29% (4)	29% (4)	7% (1)	7% (1)	14
Supported employment	21% (3)	71% (10)	43% (6)	7% (1)	14% (2)	14
Sheltered workshop	14% (2)	71% (10)	43% (6)	7% (1)	14% (2)	14
Day habilitation	36% (5)	50% (7)	36% (5)	7% (1)	14% (2)	14
Other service*	29% (2)	57% (4)	29% (2)	14% (1)	42.9% (3)	7

* Examples of other services States noted: COA accreditation for mental health/substance abuse services; accreditation of Case Management.

** Other accreditation organizations such as the Council on Accreditation (COA).

Do the 14 states with accreditation policies *require* new providers to secure accreditation within a certain time period? Nine states specify a time period (64%), while five states do not (36%). (This survey did not request state managers provide information on the time in which new providers of a service must secure accreditation.) State managers were asked to specify which services require national accreditation for new providers. Nine state managers provided information. New providers of supported employment, sheltered workshops, and day habilitation services are most frequently required to be accredited (6 states, 67%), although new providers of residential services (e.g., group homes) and supported living followed closely (5 states, 56%).

For providers other than new providers is accreditation required for contract renewal? Twelve of the 14 states with policies regarding accreditation responded to this question and revealed that states are more likely to require accreditation for day and employment contract renewal than for residential services. Table 2 below displays the frequency with which services are slated for accreditation upon contract renewal. (Note: State managers were asked to indicate all applicable service types.)

Table 2. Accreditation Required for Provider Contract Renewal by Service Type

ICF/ MR	Residential group home	Supported living	Family / adult home	Supported employment	Sheltered workshop	Day habilitation	Other
14% (2)	36% (5)	36% (5)	29% (4)	57% (8)	64% (9)	50% (7)	36% (5)

States that encourage or require accreditation were asked if there are any exceptions or waivers to accreditation. The majority of these states responded “no” (64%, 9/14 states). The five states that do allow exemptions to the requirement of accreditation base their waivers on the following grounds:

- Providers who bill under a certain dollar amount (less than \$250,000/year).
- Small agencies/sole proprietors who make less than \$100,000 per year may request a waiver.
- Providers that maintain a license to operate and meet the state’s quality review requirements for a certain length of time. (One state requires two years of meeting state quality and licensing requirements. Another state waives some oversight of providers that are in good standing with the state and have demonstrated two consecutive three year accreditations.)
- One state permits an equivalency with regard to training and experience to substitute for certification of behavioral consultants.

Are these states waiving any quality assurance requirements for accredited community providers? States were evenly split on this. Seven of the 14 states (50%) reported that they waive some aspect of quality oversight and seven (50%) do not. Of the waived requirements, certification is the most frequently waived (5 states). One state waives licensing requirements and another abbreviates the provider certification review.

Table 3 below shows the types of requirements waived in these five states. States noted all waived requirements that applied. For example, in one state, providers with national accreditation are waived of both licensing requirements and provider certification.

Table 3. State Oversight Requirements Waived for Accredited Providers

Type of Requirement	Response Count
Licensing requirements waived	1
Licensing reviews conducted less frequently	0
Licensing review is abbreviated	0
Provider certification waived	5
Provider certification conducted less frequently	0
Provider certification is abbreviated	1
Other	3

Under the ‘other’ category, three states provided information about requirements waived in their states:

- Staff certification and training requirements for HCBS waiver providers of day habilitation (includes sheltered workshop) and supported employment.
- Accredited agencies may be seen in a special review by the provider certification unit if there are any problems reported to the contracting agency or to the advocacy unit.
- Our certification process is called Endorsement. When a provider is accredited, that provider submits national accreditation credentials to the Local Management Entity who Endorses providers, and that is considered sufficient if no other regulatory or compliance issues have attended that provider.

When we analyze waived requirements in states that mandate provider accreditation for certain services (7 states), we found that only one of the seven states waives an element of its quality assurance requirements for community based providers. That state waives the provider certification review.

Of interest is whether states that mandate community provider accreditation are among those states that contract out some or all of their quality oversight to external parties. In states that require provider accreditation, none are currently contracting out quality management or oversight.

Tracking Provider Accreditation Status

Of the 14 states with policies that either require or encourage accreditation, 12 have methods in place to track a provider’s accreditation status. Tracking typically takes the following forms:

- The accreditation organization provides notice to a designated state agency (3 states).
- Providers report their accreditation status to a designated state agency (2 states).
- The state establishes another method to track accreditation status (2 states).

The majority of these states (8/14, 57%) utilize one tracking strategy. Four states utilize two tracking strategies, and two other states utilize all three tracking strategies.

Assessing the impact of policy change is important. One factor in an impact assessment is an estimate of providers that would be affected. Thus state managers were asked what percent of community providers have national accreditation. Respondents advised that between five and 100 percent of providers required to be accredited actually are accredited. Six of the 14 states that require or encourage accreditation report provider accreditation rates above 85%, with four of these states reporting 100% of required providers have accreditation.

Relevant as well is how communications operate between state agencies and accreditation organizations, particularly the outcome of accreditation reviews and any issues of concern found by accreditation reviewers. Twelve of the 14 states that require or encourage accreditation advised how accreditation status information is shared. More common is for a full provider accreditation report to be automatically forwarded from the accreditation agency to the designated state agency (33%, 4/12 states), or for the provider to give notice to the state that a review was conducted (33%, 4/12 states). One state manager advised that the accreditation agency provides notice of a scheduled review, but the state must request the accreditation report. Another state's experience is to receive quarterly reports from the accreditation agency to a designated state official of upcoming provider reviews. In this state the provider reviewed is also responsible for notifying the state agency of a scheduled survey and providing a copy of the survey report and verification of accreditation.

Also of interest is how issues of concern found during an accreditation review are shared with state officials. Communications of this type are not automatic. Six of the 12 states (43%) that require or encourage accreditation report that they are advised when issues of concern are found by accreditation reviewers, while the experience of another six states (43%) is that issues of concern are not communicated.

We also queried state managers regarding whether information flows the other direction -- from states to accreditation agencies (e.g., plans of correction). Again, 12 of the 14 states that require or encourage accreditation responded. More states reported "no" (50%, 7 states) than "yes" (36%, 5 states). To place this in context, state managers were asked what percent of accredited community providers have a current plan of

correction with a state oversight entity. Eight states provided an estimate -- seven noted that less than 15% of community service providers have a plan of correction at any point in time, and one state reported that 50% of accredited providers have some type of follow up issue. No state compares the performance of accredited providers with non-accredited providers of similar services.

What happens when a provider loses accreditation; are states tracking the loss of accreditation or the reason(s) why? The 12 states responding to this question were evenly split. Four states track the accreditation status but not the reasons for losing accreditation, four track both the loss of accreditation and the reasons, and four states do not track provider loss of accreditation.

One state is in a unique position to sharing information because it directly contracts with an accreditation organization to conduct quality reviews. State and accreditation expectations for community providers are combined. This state's contract with the accrediting organization requires the inclusion of the state's quality performance measures in key outcome domains.

Funding Accreditation

Preparing for an accreditation review and maintaining accreditation have associated costs. In 11 of the 12 states that responded to the question of how providers cover accreditation fees and costs, these costs are managed by the provider. Accreditation expenses are either folded into administrative overhead or included in service reimbursement rates. One state offered this comment, "When accreditation was mandated in the early 90's, the cost of accreditation was included in the rates for covered services. There has not been any additional funding earmarked for this purpose since then." (Note: One state pays the accreditation costs directly to the accrediting organization for accreditation of its regional centers. Regional centers are the brokers of services and do not provide direct services.)

Public Reporting

The majority of states (67%) that encourage/require accreditation do not share accreditation review information with the public (8 of 12 states responding to this question). Four of the 12 states (33%) do share accreditation information with the public, and their methods are:

- Posting on the state agency website (1 state)
- State agency reports (1 state)
- Sharing a report upon request (1 state)
- Permitting the provider agency to disseminate information the agency chooses to share (1 state)

With respect to the level of detail provided to the public, three states provided feedback. Two states note the provider review information only in summary form, while the other state offers both summary and detail reports. HSRI recently conducted an environmental scan of state websites to determine the extent to which state agencies are posting provider performance information. While there is somewhat more activity with posting provider performance generally, posting the results of national accreditation is not yet mainstream. (Note: This survey did not inquire whether states have policies and procedures regarding community providers noting accreditation status on the provider's website or publications.)

States' Recommendations to Other States

Regardless of a state's practices pertaining to national accreditation of community providers, Missouri officials sought their peers' opinions and recommendations pertinent to the adoption of accreditation policies. The predominant message from states that responded to this survey is that accreditation is an adjunct quality assurance process that complements, but does not replace, state level quality monitoring. Very few states waive any part of the quality oversight functions for community providers with national accreditation. Accreditation, while recognized as a valuable indicator of a provider's quality of service delivery, is not recommended to stand in lieu of a state's responsibility to assure that individuals receiving services are meeting state standards. States participating in this survey recommend utilizing national accreditation as one of the sources of information to discern performance.

State feedback was prompted in three areas: 1) management and coordination with accreditation organizations, 2) integration of accreditation with ongoing public monitoring, and 3) consistency of accreditation requirements with CMS and other state rules. Eleven states provided commentary for Missouri officials.

States' suggestions regarding management and coordination with an accreditation organization stressed utilizing performance-based contract language that specifies the responsibilities of both the state and the accreditation organization. Because accreditation organizations are private entities, communication and information sharing should be explicit -- including when and how to share concerns about a provider's performance. (One official advised checking with legal counsel concerning the liability of sharing provider performance indicators with the accreditation organization.) Once a formal agreement is in place, quarterly or more frequent calls between the accrediting organization and state agency should be instituted.

With respect to integrating accreditation requirements with ongoing state monitoring (e.g., health and welfare), respondents cautioned states from substituting accreditation for their own quality reviews. Accreditation reviews are too infrequent and even

accredited providers have had serious problems with meeting health and safety assurances resulting in cancelled contracts. Accreditation as a supplemental quality review is supported. The following suggestions (direct quotes) for integrating the state's requirements with accreditation requirements capture the range of recommendations:

- There should be a direct crosswalk between the state's outcomes and those of the accreditation agency, so that agency performance can be compared. Otherwise it's comparing apples and oranges.
- (State agency) does not rely solely on the accreditation process when approving "deemed status" for licensure/certification. In order to achieve "deemed status", the provider must be in substantial compliance with (state agency) standards and the (state agency) reviews the request against other evidence such as complaints filed, incident reports, consumer satisfaction surveys to determine that the evidence does not indicate a pattern of non-compliance or pervasive non-compliance. If a provider is issued "deemed status certification/licensure", the provider must sign an agreement stating that they will notify (state agency) immediately after receipt of notification of a change in accreditation status, notify (state agency) within 14 calendar days of the provider's receipt of notice of a pending survey by the accrediting organization, submit all quality improvement plans or other documents submitted to the accrediting organization, and authorizing the accrediting organization to release information to (state agency) upon request. The agreement also states that (state agency) retains the right to have access to the premises, staff, individuals served and their families and all records of the provider at all times. Our policy provides that (state agency) may withdraw deemed status if a complaint concerning substantial compliance with a health or safety standard is founded, if an abbreviated review of the provider, service concern investigation, or survey finds instances of noncompliance with state standards or if the national accrediting organization downgrades or withdraws its accreditation.
- (State agency) is currently contracting with CQL for its quality enhancement initiatives. Accreditation is currently voluntary for providers. Any agency that is certified or accredited will receive a deemed status from state regulation oversight reviews. The state is considering a two tiered certification process to include an administrative review and a clinical review. The clinical review would be more closely aligned with the outcomes of CQL's Basic Assurances. ... The hope is that providers would have three choices for the purposes of certification and that all three would move the system toward a more outcome CQL based philosophy. (State) will consider financial incentives and supports in the future for agencies who wish to seek certification or accreditation through the council.

With respect to *consistent expectations across state and federal systems*, states obviously find the concept of consistency attractive as it would be reinforcing to providers and offer standardization in evaluation and reporting. However, a number of states note that the accreditation processes do not meet the health and safety assurances required by CMS. While state managers do note some areas of review and oversight coherency, most do not perceive de facto integration between state expectations, accreditation requirements, and CMS standards. There is even divergence of opinion over which of the relevant accreditation organizations is most closely aligned with CMS requirements. Two respondents note that CQL seems more aligned with CMS requirements, while other states noted CARF presents so. What is not widely known among states is that the accreditation agencies (CQL, CARF) have cross walked CMS assurances with accreditation requirements. (Presumably a state manager may request these from each of the accrediting bodies.)

In the absence of integrated expectations state quality management managers are concerned that there not be conflicting expectations on providers. Presented below are the experiences of three states regarding consistency of expectations across the system:

- With our state's history with CMS and the federal courts, we found that our monitoring requirements had to cover different things than what accreditation bodies were typically reviewing. For example, in the arena of protection from harm, we were required to look much more in detail at incident management and other such issues than the accreditation body. It seems that with an accreditation body, certain assumptions are made about the basic status of those organizations that are pursuing accreditation. Our state's oversight has to be more rigorous at this point.
- Comparisons between state rules and regulations and the standards/outcomes of the accrediting bodies should be done to determine what may or may not be waived for accredited agencies. Typically, state regulations are much more prescriptive than accrediting standards. So, the agency may meet the broadly stated accreditation area but is found lacking with the more specific state regulations. CMS accepts JCAHO accreditation as meeting the CMS requirements, and CMS conducts look-behind surveys of a sample of hospitals/agencies for validation. I don't believe CARF and/or CQL are viewed by CMS in this same way.
- (State) incorporated many of the current CARF standards into our licensing/certification standards along with additional standards that were either already in place or deemed necessary to add. In our conversations with CARF, they have agreed to review against our standards that are not currently within

their requirements when on-site in (state). At this time, (state) feels that CQL is more in line with the state's direction for systems change and is more consistent with CMS requirements than other accrediting organizations.

IMPLICATIONS FOR MISSOURI DMH QUALITY MANAGEMENT

States responding to this survey recommend national accreditation be one of the streams of information to discern a provider's level of performance. *Very few states waive any part of the quality oversight functions for community providers with national accreditation.* Although accreditation reviews are periodic, state managers consider the time between on-site accreditation reviews to be too infrequent to provide adequate assurance that a provider is performing to expected standards.

Any formalization of requirements for community providers should be cognizant of the following:

- Need to formalize sharing of information between accrediting bodies and state
- Tie standards to state requirements
- Tie standards to national requirements including the Centers for Medicare and Medicaid Services (CMS) Assurances

If Missouri DMRDD is looking to reduce costs by eliminating some aspect of state quality oversight in lieu of national accreditation, then an analysis of accreditation costs that providers will incur to prepare for a survey and maintain accreditation is necessary – as such costs typically are folded into a provider's overhead. Missouri officials may want to compare the costs of all providers that would need to be accredited to costs of the quality oversight function under consideration to be waived. Along with an analysis of costs, the benefits of accreditation review information compared to state quality oversight review information should be assessed.

National accreditation is another mechanism for determining a provider's performance and states need information to track and trend performance on both individual providers as well as systemically. Including the accreditation status of providers is a relevant quality indicator to track and report out to stakeholders. With CMS' increased emphasis on the demonstration of quality oversight for operating home and community based waivers, states are now including provider accreditation as evidence of assurances. However, it is rare for a state to abnegate oversight to an external entity not under the control of the state. States at this time are much more comfortable integrating accreditation into their other forms of quality oversight.

Should Missouri determine that national accreditation could be useful for one or more services, an examination of implementation issues should include:

- Is there a clear understanding of performance expectations and accountability?
- What will the financial /administrative impact be on providers?
- What areas of accountability are covered by what oversight entity?
- Is there any redundancy that is unwarranted?
- How will the oversight entities communicate?
- Which entity will be designated as the lead agency for any follow up with an underperforming provider?

ENDNOTES

ⁱ Mays, Glen, Ph.D., M.P.H., Can Accreditation Work in Public Health? Lessons From Other Service Industries, Working Paper Prepared for the Robert Wood Johnson Foundation, November, 30, 2004.

ⁱⁱ Council for Higher Education Accreditation (CHEA)

Attachment A: Survey Questions

1. Does your state have a formal policy that either encourages or requires providers of community based services to be accredited by a national accreditation organization?

- Yes, accreditation is required. (Please skip to question #3.)
- Yes, accreditation is encouraged. (Please skip to question #3.)
- No, State has no formal policy that either requires or encourages provider accreditation.

2. If your state does not have a formal policy, is it in the process of adopting such a policy?

Yes

No (If you answered 'No', please skip to question #26.)

3. On what is your accreditation policy based? Check all that apply.

- Statute
- Administrative rule
- Court ruling or mandate
- Other. Please specify the authority in the text box below.

4. Please indicate in the table below the extent to which your state policy stipulates which accreditation entities should be used by service type.

Service Type	No policy	Accreditation Policies			
		CARF	CQL	JACHO	Other accreditation entity (specify)
ICFs/MR					
Residential (i.e., group homes)					
Supported living					
Family care/ adult homes					
Supported employment					
Sheltered workshops					
Day habilitation					
Other?					

5. For what length of time has your state policy encouraged or required national accreditation?

6. For new providers, does the State REQUIRE that accreditation occurs within a specific time period following enrollment?

- Yes
- No (If you answered 'No', skip to question #8.)

7. Please check which services are REQUIRED to be accredited for new providers. Check all that apply:

- ICF/MR
- Residential (group homes)
- Supported living
- Family care/adult homes
- Supported employment
- Sheltered workshops
- Day habilitation
- Other service type. Please specify the service type below.

8. For providers other than new providers, is accreditation REQUIRED for contract renewal? Please check a 'yes' or 'no' response for each category of service.

- ICF/MR
- Residential (group homes)
- Supported living
- Family care/adult homes
- Supported employment
- Sheltered workshops
- Day habilitation
- Other service type. Please specify the service type below.

9. Are there any exceptions, waivers, or thresholds to the expectation of accreditation (e.g., size of agency, amount of revenue generated, amount of billing, etc.?)

- Yes. Please describe these exception/waivers/thresholds in the text box below:
- No

10. Does the state waive other quality assurance requirements if an agency is accredited?

- Yes
- No (If you answered 'No', skip to question 12.)

11. If you answered YES to Question 10 above, please indicate the requirements that are waived. Check all that apply:

- Licensing requirements waived
- Licensing reviews conducted less frequently
- Licensing review is abbreviated
- Provider certification waived
- Provider certification conducted less frequently
- Provider certification is abbreviated
- Other. Please describe in text box below:

12. What percent of community providers in your state have national accreditation?

13. How is a provider's national accreditation status tracked in your state?

- Provider tracks and reports to designated state agency
- Accreditation organization advises designated state agency
- State tracks
- Other tracking process. Please describe in text box below:

14. When national accreditation reviewers uncover issues of concern, is this information communicated to the State?

- Yes
- No

15. How is information from accreditation organization reviews provided to the State?

- Full provider accreditation reports are forwarded to the State from the accreditation agency automatically
- State is given notice from the accreditation agency that a review was conducted but the State must request report from accreditation agency
- State is given notice from the provider agency that a review was conducted
- State does not have a method to share information from accreditation agencies
- Other (please specify in box below)

16. For providers that have plans of correction with a state oversight entity (licensure, quality monitoring, substantiated abuse, neglect, exploitation, etc.), is the provider's plan of correction and progress shared with the accrediting organization?

- Yes
- No

17. What percent of accredited providers are currently on some type of plan of correction with the state agency? (If this information is not readily known, please provide your best estimate.)

18. Does your state track providers that have lost accreditation and the reason(s) why?

- Yes, State tracks provider's accreditation AND the reason(s) for losing accreditation.
- Yes, State tracks provider accreditation but does NOT track the reason(s) why accreditation is lost.
- No

19. Does your state contract directly with an accreditation agency to carry out reviews?

- Yes
- No (If you answered No, please skip to question #21.)

20. Does your contract include additional standards dictated by state rules/policies?

- Yes. Please describe the additional standards in the text box below:
- No

21. Does your state compare the performance of accredited providers with performance of non-accredited providers serving similar individuals?

- No
- Yes. Please note the type of comparison in the text box below:

22. How do providers cover fees or costs associated with securing and maintaining accreditation? Check all that apply.

- Providers pass accreditation costs on to state
 - State funds accreditation costs directly
 - Providers absorb accreditation costs
 - Legislature is planning to provide support in future budget allocations
- Other. Please specify your State's arrangements in the text box below:

23. Does your state share national accreditation reports and outcomes with the public?

- Yes
- No (If you answered No, skip to question 26.)

24. How is the information shared?

- MR/DD agency website
- Other state website
- MR/DD agency reports
- Other. Please specify how information is shared in the text box below:

25. Is the information shared provided in summary form or in detail?

- Summary
- Detail
- Both summary and detail accreditation reports are available.

26. Do you have any recommendations in the following areas for states considering accreditation policies:

- Management and oversight of the performance of the accreditation organization?
- Integration of accreditation with ongoing public monitoring (e.g., health and welfare)?
- Consistency of accreditation requirements with CMS and other state rules?

27. OTHER THOUGHTS? Please use this space to provide any additional narrative, comments, or explanations.

28. Would you like to receive a copy of the report?

- Yes
- No

29. Missouri DMRDD officials may want to follow up with a few states with specific questions. Does HSRI have permission to identify you as the respondent for follow up?

- Yes
- No

Thank you very much for participating in this survey. We will be sharing the report as soon as possible.